Department of Human Services
Parent Income/Asset Declaration

The Department of Human Services (Child and Family Services or Juvenile Justice Services) is requesting the information on this form so we can determine if your child qualifies for Federal medical and room/board benefits while in our care. ***Please answer all questions on this form and return to your caseworker or eligibility worker as soon as you can.*** *Include information for persons living in the home during the month and year listed in Box 1 below.*

Box 1
Month/Year _____

Who was legally responsible for the child at the time care responsibility was given to the Department of Human Services *(Division of Child and Family Services or Division of Juvenile Justice Services)*?
_____ Father_____ Mother_____ Both _____ Other (Who_____)

Father's Name _____ Social Security # _____

Mother's Name _____ Social Security # _____

Child(ren) in Agency Care	Date of Birth	Gender	Race	Social Security Number	Place of Birth	Citizen Y/N

**List additional children on back.*

Box 2

Household Information - Who, other than child(ren) in agency care, lived in your home during the month listed in box 1?

Name	Relationship to the child(ren) in agency care	Date of Birth

Box 2 cont.

Household Information (cont.) – Provide information for the month listed in Box 1.

Are both of the child(ren) in agency care parents living in the home listed above?…… **Yes** **No**

If no, please indicate the reason for a parent's absence.

_____Death _____Divorce _____Separation

_____Jail _____Other *(explain)*_____

Will the parent continue to be absent for more than 30 days?…… **Yes** **No**

Is anyone in the household disabled?…….. **Yes** **No**

*Who?*_____

Is the disabled person receiving any of the following types of income?…… **Yes** **No**

_____SSI _____Worker's Compensation _____SSA

Is a parent currently unemployed?…….. **Yes** **No**

*Parent's Name*_____

Has this parent voluntarily quit a job in the past 30 days?…… **Yes** **No**

Has this parent refused an offer of employment within the past 30 days?…….. **Yes** **No**

Box 3

Income – For each person living in the home, list all gross income he or she received in the month listed in box 1.

Name	Employer	Start Date	Hours worked per month	Hourly Wage

Did anyone living in the home receive the type of income listed below during the month listed in box 1? Please check the income type.…… **Yes** **No**

- ☐ Social Security (SSA)
- ☐ Supplemental Security Income (SSI)
- ☐ Veteran's Benefits
- ☐ Unemployment Benefits
- ☐ Pension/Retirement
- ☐ Dividends (Stocks/Bonds)
- ☐ Alimony
- ☐ Child Support
- ☐ Property Rent
- ☐ Tribal Funds
- ☐ Other (specify)

*Who?*_____

*Amount?*_____

Box 4

Expenses – Please answer the questions listed below for the persons living in the home during the month in box 1.

Is child support or alimony being paid by someone living in the home?……**Yes** **No**

*If yes, give name and amount paid:*_____

Does anyone in the home pay for dependent care so they can go to work?……**Yes** **No**

*If yes, list names and amounts:*_____

Box 5

Assets – List any assets owned by people living in the home during the month listed in box 1? Please check the asset type.

- ☐ Checking Account
- ☐ IRA/Stocks/Bonds
- ☐ Trust Funds
- ☐ Funeral Plans
- ☐ Savings Account
- ☐ Home or condo (not living in)
- ☐ Cash
- ☐ Property
- ☐ Whole Life Insurance
- ☐ Trailers
- ☐ Livestock

Owner	Type of Asset	Joint? Y/N	Account Number	Value/Balance	Amount Owed

Vehicles - (Car, Snowmobile, Motorcycle, Truck/Van, Boats)

Owner	Type of Vehicle	Model	Year	Licensed? Plate # / State	Value	Amount Owed

Third Party and Insurance Information

Name: | Birth date:

1. Does the child(ren) in agency care currently have health insurance including Medicare? **Yes No**
   Do not list Medicaid, CHIP, or PCN. If you answered yes, complete Section 1.
2. Has the child(ren)in agency care had insurance that has ended in the past 6 months? **Yes No**
3. Does the child(ren) in agency care have insurance available that you have not enrolled in? **Yes No**
   If you answered yes, complete Section 2.
4. Does the child(ren) in agency care have a major medical need? **Yes No**
   Who has the medical need?_____What is the medical need? _____
   If yes, do you have: 1. Insurance available, which you have not purchased? **Yes No**
   2. Insurance that has ended in the past 60 days? **Yes No**
   *Pregnancy is considered a major medical need. If you answered yes, enter the information in Section 2.
5. Has the child(ren)in agency care been injured in an accident or assault? **Yes No**
   If you answered yes, complete Section 3.
6. Is any other person required to pay medical expenses for the child(ren) in agency care? **Yes No**
   If yes, person's name _____ Phone Number _____
7. Has anyone in your household ever served in the military? **Yes No**
   Name _____ Dates of Services _____

Section 1 – Insurance Information ***(Complete this information if you answered YES to question 1.)***

Name of Insurance Company_____ Phone #_____
Address of Insurance Company _____ Group # _____
_____

Policyholder Name Policy #

Name of Insurance Company_____ Phone #_____
Address of Insurance Company_____ Group #_____

_____

Policyholder Name_____ Policy # _____

Policyholder Date of Birth_____ Policyholder Social Security Number_____
If insurance is through an employer, list employer name and phone _____

Premium $ _____ Date Due_____ How often?_____

Names of foster child(ren) covered _____

Section 2 – Buy-Out/PCN Information ***(Please complete if you answered yes to question 2 or 3)***

Name and Phone of Insurance Company _____

Policyholder Name_____ Policy #_____

Employer Name and Phone (if applicable) _____

If not through an employer, how is insurance available? _____

Section 3 – Accident or Assault Information (***If you answered NO to question 5, DO NOT complete this section.)***

Please check the type of incident:

- ☐ Automobile ☐ Assault ☐ Dog Bite
- ☐ Work-related ☐ Slip/fall ☐ Medical Malpractice
- ☐ Other, please explain _____

Name of person (s) injured: _____ Date of incident:_____

Was a police report filed?……. **Yes** **No**
Police Department_____ Report number_____

Name of Attorney:_____ Phone number _____

Please read and sign the following statement.

I certify that the above information is true and correct. I give my permission for any information on this form to be verified.

_____ _____ _____
***Parent Signature* *Date* *Phone #*

_____ _____ _____

***Parent Signature* *Date* *Phone #*

*** Only the person(s) who were legally responsible for the child at the time care responsibility was given to the State of Utah should sign above. Your cooperation is appreciated.*